Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7103	A. BUILDING _____ B. WING _____	05/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, COOKEVILLE	815 SOUTH WALNUT AVENUE COOKEVILLE, TN 38501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments An annual Licensure survey and complaint investigation #18023 and #25501, were completed on May 24, 2010, through May 26, 2010, at NHC Cookeville. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000	No deficiency sited - No POC provided	

Division of Health Care Facilities

JONES — ADMINISTRATOR — 6/9/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

JUN 10 2010